ROYAL PHARMACEUTICAL SOCIETY
Scotland

SCOTTISH PHARMACY BOARD MEETING

Minutes of the meeting held on Wednesday 22 April 2015 at Holyrood Park House, 106 Holyrood Road, Edinburgh EH8 8AS.

PUBLIC BUSINESS

Present:

Prof John Cromarty (Chair)
Dr John McAnaw (Vice-Chair) (JMcA)
Mr Ewan Black (EB)
Dr Anne Boyter (ACB)
Mr Jonathan Burton (JB)
Mr Alan Glauch (AG)
Ms Sandra Melville (SM)
Mrs Kim Munro (KM)
Dr Ailsa Power (AP)
Mrs Andrea Smith (AS)
Mr David Thomson (DT)

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In attendance

Ashok Soni (ASh), RPS President, Alex MacKinnon (AMacK), Director for Scotland, Aileen Bryson (ABr), Scottish Practice & Policy Lead, Annamarie McGregor (AMcG), Professional Support Pharmacist, Susanne Cameron-Nielsen (SCN), Head of External Relations, Elspeth Bridges (EBr), Membership Development Manager, Deborah Stafford (DS), Educational Development Pharmacist, Carolyn Rattray (CR), Business Manager, Beth Robertson (BR), PA / PR Intern, Claire Carlyle (CC), Business Support Assistant.

Helen Gordon (HG), Chief Executive, and Stephen Robinson (SR) RPS Correspondent, joined the meeting by video-conference.

15/27. Welcome

The Chairman welcomed Board Members, Ashok Soni (ASh), RPS President, and Zachary Jordan and Emmanuel Carandang, two pharmacy students (work experience placements from North Carolina, who were attending the public business meeting at the invitation of Jonathan Burton (JB)). The Chair also welcomed two new members of staff – Beth Robertson (PA / PR Intern) and Claire Carlyle (Business Support Assistant) and Helen Gordon (HG) Chief Executive, and Stephen Robinson (SR) RPS Correspondent, who were attending the meeting by video conference. Professor Peter Noyce, Chair of Pharmacist Support, was also welcomed to the meeting; Board Members (BMs) were advised that Prof Noyce would attend the meeting for his agenda item and then would have to leave as he had another engagement.

15/28. Apologies

The Chair advised BMs that he would have to leave the meeting at lunchtime and that John McAnaw (JMcA) Vice-Chair, would chair the afternoon sessions.

15/29. Declarations of Interest

Board members were reminded to declare any specific interests prior to discussion of agenda items.

15/30. Confirmation of Board Meeting Minutes

The Scottish Pharmacy Board

approved

the minutes of the public business part of the Board Meeting held on Wednesday 21 January 2015 with one amendment:

15/25. Dillip Nathwani – Dillip Nathwani was awarded an OBE rather than an MBE.

Action point: CR to update the minutes and then publish on www.rpharms.com.

15/31. Matters Arising

P.2. 15/04 - Professional Indemnity Insurance: It had been agreed at the January meeting that professional indemnity insurance should be included on the SPB Public Business agenda for the April meeting; it will now be included on the SPB Public Business Agenda for the meeting to be held on 17 June 2015.

P.17 15/22 - *Prescription for Excellence* (*PfE*): The Chair advised that he has not yet been able to confirm with Elaine Muirhead, Scottish Government (Scot Govt), that it is acceptable for all *PfE* papers to be emailed to SPBChair@rpharms.com as well as the Chair's personal email address.

P. 21 15/25 - Pharmacy Schools' Council: RPS President, (ASh), confirmed that he had attended the Pharmacy Schools' Council meeting with the purpose of 'understanding where they are and what their plans are'. Discussions took place around the potential opportunities for post-graduate rather than under-graduate programmes. ASh confirmed that there will be a new academic representative at the next RPS Assembly meeting, as Larry Goodyer would be retiring.

P. 22 15/25 - Dillip Nathwani: Alex MacKinnon (AMacK) confirmed that the letter of congratulations to Dillip Nathwani had been sent out in the Chair's absence with AMacK signing it on the Chair's behalf. AMacK thanked Anne Boyter (ACB) for drafting the letter.

Action point: Professional Indemnity Insurance: to be included on the SPB Public Business meeting agenda – 17 June 2015

Action point: Chair to confirm with Elaine Muirhead, Scottish Government (Scot Govt), that it is acceptable for all PfE papers to be emailed to SPBChair@rpharms.com as well as the Chair's personal email address.

15/32. Presentation from Professor Peter Noyce, Chair – Pharmacist Support.

The Chair welcomed Prof Noyce, Chair of Pharmacist Support (PS), to the meeting. Prof Noyce introduced himself and explained that there were five reasons for his presence at the meeting, they were:

- to explain what happened to the RPS Benevolent Fund. The Benevolent Fund has been re-established as PS.
- to demonstrate the progress of the Charity
- to increase awareness of PS and it's services to pharmacists in Scotland; he explained that Scotland has a 'lower usage of services' than in other areas of Great Britain.
- to advise BMs that the charity became a charitable incorporated organisation in January 2015 and is listed with Companies House as well as the Charities Commission; this has increased levels of governance and puts it alongside the larger charities
- PS started actively fundraising in 2014, raising £35k in its first year. Prof Noyce explained that Benevolent Societies operate in a different way to charities in that income depends on the interest from reserves; this is not sustainable. Large charities are generally run on a short-term model, holding only six months' operational reserves; this is sustainable because of predicted regular donations.

PS has been developing its strategy; its Mission statement is: *'Supporting pharmacists through life'* (from the professional cradle to the grave).
The services are tailored to needs, examples are:
Student bursaries: support for pre-registration (pre-reg) trainees is increasing with the mismatch of graduates to pre-reg places and also support when they are treated unfairly. Other areas of support are illness, disabilities and dependents. Services provided are:
Wellbeing support:

- **Wardley wellbeing service:** The Benevolent Fund was left a legacy of more than £1m for the prevention or relief of stress. This legacy has allowed the charity to research and develop a range of services. A full-time councillor is about to be employed.
- **Listening Friends Helpline**

Health Support: Addiction rehabilitation is one of the core services, provided in association with another charity, Action on Addiction. These are residential programmes. Addiction is a challenging issue and although rehabilitation is an expensive provision for a charity, but it is a crucial service. The General Pharmaceutical Council (GPhC) provides information on Pharmacist Support if a pharmacist has been suspended because of a health issue.
Financial support:

- **Debt re-scheduling and access to benefits:** PS works closely with Manchester Citizens Advice Bureau to provide support with debt re-scheduling and access to benefits. PS provides grants and awards; because of recent government legislation, charities are no longer allowed to provide loans.
- **Student bursaries:** An initiative was piloted in 2014; to date, in 2015, 48 applications have been received; PS will be able to offer 12-15 with a maximum bursary being £6k.

General support:

- **Information and enquiry service**
- **Employment advice**

Recent achievements:
In the 7 years since Pharmacist Support was established, it has provided 7,000 acts of support and £1.4m in financial assistance. It has gained over £9m in financial gains for service users and has launched two new services within its Wellbeing Support programme: the Wardley Wellbeing Service and the Listening Friends Helpline.

Fundraising:
Pharmacist Support has now started to fundraise with the ambition to make Pharmacist Support 'the charity of choice'. It was noted that BMs can support the charity in a variety of ways, for example, through individual giving, payroll giving, participating in events and challenges, individual sponsorship at group / organisation level, employer based and legacy giving. A recent development has been giving by text: **Text PHAR14 and amount to 70070.**

Prof Noyce concluded his presentation with a number of requests for BMs; BMs were asked to:

- 'spread the word about PS' through their networks.
- Organise / participate in fundraising events for PS
- Engage with 175 activities (to match the anniversary, i.e. 175 years since the Benevolent Fund was established)
- to become part of a PS Stakeholder / Partnership group. Any BMs wishing to become part of this group should contact: PS, 5th Floor, 196 Deansgate, Manchester, M3 3WF.

John McAnaw (JMcA) asked about annual fundraising targets, taking into account the six months' operational costs that are required at all times. Prof Noyce confirmed that in 2016, the target will be £175k (to reflect the anniversary) increasing in future years to £300k.
Anne Boyter (ACB) commented that the feedback about PS that she has received from her students at Strathclyde has been fantastic and recommended that the Scottish Pharmacy Board support PS.
Ailsa Power (AP) noted that National Health Education for Scotland (NES) and RPS are running a conference on 26 May and PS could have a display.
EBr asked if a video with key points is available that could be shown at LPF events. Prof Noyce acknowledged that a generic video, to raise awareness of PS, would be beneficial and that this would be considered. EBr also suggested that information about PS could be noted in email signatures.
DT thanked Prof Noyce for his presentation and suggested that, although RPSGB and PS had to separate for legislative reasons, there might be mileage in having a closer relationship with RPS, perhaps by promoting PS as a Member benefit. ASo suggested that there might be an opportunity for promotion at the RPS Fellows' Dinner.
HG thanked Prof Noyce for his presentation and confirmed that there is a good and growing relationship between the Society and PS.

The Chair thanked Prof Noyce for his presentation and suggested that further discussions should take place at a strategy day and that suggestions will be followed up.

- **Action point:** CR to circulate presentation to BMs in Friday Update
- **Action point:** BMs and staff were asked to promote PS through their networks and at events.
- **Action point:** BMs wishing to be a part of the PS stakeholder / Partnership group should contact Pharmacist Support, 5th Floor, 196 Deansgate, Manchester, M3 3WF, tel: 0808 168 2233, email: info@pharmacistsupport.org..
- **Action point:** AP to contact PS re: having a display at the NES / RPS Conference on 26 May.

- **Action point:** ASo to consider promoting PS at the RPS Fellows Dinner.
- **Action point:** Pharmacy Support to be included as an agenda item at an SPB strategy day.

15/33. Scottish Patient Safety Programme (SPSP)

Andrea Smith (AS), SPB Board Member and National Clinical Lead (Pharmacy) for the Scottish Patient Safety Programme (SPSP) gave a verbal update (with presentation) on the SPSP.

AS asked 'why should we bother'? There are adverse events in primary care that cause 1 in 20 deaths in hospital, 5–17% of admissions are linked to an adverse event and 5% of prescriptions contain an error; to put this into context, 98.8 million prescriptions were dispensed in 2014, which would mean that approximately 5 million prescriptions contained an error. The Acute Programme started in 2008, moving into mental health, maternity and children and then into primary care for GPs; there is recognition that community pharmacists have to be an integral part of the SPSP. AS noted that although the SPSP started in Acute Care in America (AHI), progress in Scotland has now overtaken the American model.

The ambition of the SPSP is to involve pharmacists working in primary care to drive improvements in communication and closer working between pharmacy teams and GP practices. There are 3 areas of focus within the 2 year programme:

1. High risk medicines
2. Medicines reconciliation, an area the presents significant challenges, an example being acute patients being discharged to GPs
3. Raising awareness of what a safety culture should look like: 'as the aeronautical industry is a safety critical industry, so pharmacy is a safety critical industry'.

The SPSP is a Health Foundation funded initiative for two years and Health Improvement Scotland (HIS) provides a progress report to the Health Foundation on a quarterly basis. Also, HIS, the four participating health boards (NHS Fife, Greater Glasgow & Clyde (GGC), Grampian and Highland) and the evaluation team will report on the improvements journey through the BMJ Quality Online Platform, to facilitate publication at the end of the Collaborative.

AS described the Model for Improvement (MFI); it is made up of two parts – the thinking part and the doing part (PDSA – plan, do, study, act). The MFI has been adopted in Scotland and is included in the Quality Strategy and continuous quality improvement within the Scot Govt, within HIS and elsewhere.

AS explained the use of driver diagrams and gave an example of a driver diagram from NHS Highland. The aim was to reduce avoidable harm with medicines, the diagram works from right to left, the first column being primary drivers followed by a 2nd column, secondary drivers; the secondary drivers can influence the aim. Driver diagrams help to look at issues and how best to resolve them and improve.

The NHS Boards involved were asked to consider four questions when developing interventions:

- What difference could you make?
- What is the patient safety issue?

- What can the pharmacist influence?
- How will this be measured?

Care Bundles (a bundle of interventions) have been proved to reduce harm in clinical practice. AS went on to explain that care bundles are groupings of best practice with respect to an intervention that, individually, can improve care, but when applied collectively may result in substantially greater improvement. A bundle is a means to designing a standard approach when delivering elements of care.

The SPSP project is based on a 'Breakthrough Collaborative model', a short term learning system which has proved to be very successful. The project started in November 2014 and will last for two years. The Collaborative is made up of the national SPSP team NHS Board, the four Health Boards each of which are slightly different: NHS Fife has 7 community pharmacy teams, NHS Grampian has 5, and GGC has 10 including Paisley which is already involved in a change programme; NHS Highland is using 3 community teams plus 2 which are working with dispensing GP practices.

In Year 1, high risk medicines are being considered; NHS Fife and NHS Grampian are looking at warfarin whilst NHS Highland and NHS GGC are considering non-steroidal anti-inflammatory drugs (NSAIDs). Each Board has developed its own bundle and even though they might be focussing on the same issue, the bundles are different; patients are involved in the interventions.
In Year 2, the focus will be on medicines reconciliation; this will be about communication, the review of current medication, reviewing the next prescription for discrepancies, highlighting with the prescriber and reconciliation; it has been found that there is a significant challenge around patients who are on compliance aids. A process mapping event is planned for June together with a visit to Forth Valley hospital where work on this is developing.

Support for those involved in the project takes the form of Board support, use of webex, flash reports and site visits.

Safety Climate Survey: This was tested in GP surgeries for two years and is now in the Qualities and Outcomes Framework (QOF). The latest response rate for QOF (2014) showed that 91% of practices in Scotland completed the safety climate survey; in Fife, the response rate was 100% and has been adopted by GPs. A safety climate survey is being conducted in the pilot pharmacies; it is live at the moment (started on 1 April and will end 8 May). The results of the safety climate survey will be anonymous to individual pharmacies, but an individual pharmacy will be able to see how it compares to pharmacies as a whole. The measurable features of 'Safety Climate' (Culture) are leadership, communication, working conditions, safety systems and teamwork. There are challenges for pharmacy, for example around teamwork that other HCPs might not experience.

The evaluation of the Safety Climate Survey is being conducted jointly by NES and Strathclyde University; it is a validated tool that is theory driven but with quantitative and qualitative elements.

Milestones so far:

- A reference group was convened to develop a bid to the Health Foundation.
- A steering group was convened made up of NES, Directors of Pharmacy (DoPs) and HIS; the 4 Health Boards were also represented.

- May 2014 - The four Health Boards were recruited in May 2014.
- August 2014 – Induction event for all the teams
- December 2014 – National learning session; also started to collect baseline data (this means that now in Month 4 of collecting data)
- March 2015 - All four Health Boards held their local learning sessions; a great opportunity for local pharmacies to feedback on activities
- 1 April 2015 – Safety Climate Survey opened

SM noted that this 'is a huge challenge but very worthwhile'; she has been practising 'patient safety' in this way for seven years and gave examples in the hospital setting that have made a difference, examples being: in intensive care if the top of the bed is elevated by not less than 45%, the rate of aspirational pneumonia will be reduced drastically; also, the 'surgical pause'. SM asked that the Collaborative could consider, as part of its project, ways of ensuring that the information on the Emergency Care Summary is transparent on admission to hospital; she noted that one of the ways that medicines safety is improved in Oban is to ensure that the medicines' reconciliation is correct on discharge. SM noted that it had been found that many patients, on discharge who were prescribed Warfarin didn't know when they should have their INR checked; at Oban, on discharge, all patients prescribed Warfarin are given a credit style card, matching their Warfarin which has an appointment already made for them to have their INR checked.
Ewan Black (EBl) asked how changes are measured, other than anecdotally, to demonstrate that tangible differences are being made to patient outcomes. To be able to measure results, data is crucial and pharmacists are being asked to feed these results into their health boards who are collating information; results are shown there. AS confirmed that pharmacies are not doing this in isolation and that communication is key; she noted the SBAR pilot in NHS Highland.
ASh noted that by creating a reporting and learning culture generally will support medicines rebalancing; pharmacists will feel able to report and it will become part of the culture that the SPSP is trying to achieve.
AMcG noted that previously the Society had supported the SPSP in the hospital sector by holding LPF events across Scotland; it was noted that the RPS would be keen to have the opportunity to help support the roll-out of this initiative through LPFs, etc. and the RPS Quality Systems resource.

The Chair thanked AS for her presentation and noted that, as the SPB represents pharmacy in all the Scottish Health Boards, that this subject should be considered in more depth at a future strategy day.

Action point: CR / AMacK to add SPSP as an agenda item at the June SPB meeting.

15/34. National Health Education Scotland (NES) / RPS Educational Project

Deborah Stafford (DS), Educational Development Pharmacist, gave an update on the joint NES / RPS educational project.

DS explained that she has been conducting a scoping exercise to identify training and education opportunities for pharmacists within NHS Scotland; focus is on programmes provided by NES, RPS and the two Scottish schools of pharmacy (SoPs). DS has pulled together programmes that are available and those that are accessed and is now in the process of reviewing the results with stakeholders, i.e. specialist interest groups (SIGs) who have been identified through the Directors of Pharmacy (DoPs), to see if there are any other

training opportunities that have not been captured. DS also has meetings arranged with Prof Marion Bennie, Prof of Pharmacy Practice at Strathclyde, and Dr Anita Weidmann, Senior Lecturer at Robert Gordon University (RGU); these meetings will focus on the SoPs' Masters' Degree courses. DS has identified the large multiples to approach but asked BMs to provide details of independent community pharmacy contractor organisations to approach.

NES Training opportunities:
Vocational Training Stage 1 (VT1) - Pre-registration: In Scotland, Stage I is very much managed within NES and the GPhC performance standards are used to form the basis of the programmes.
Vocational Training Stage 2 (VT2) – General Hospital Pharmacist: This very much lies within the managed service, but consideration is being given to how it may be developed for community and practice based pharmacists in the future. Stage 2 is the mainstay of the programme accessed by early years' pharmacists.
Vocational Training Stage 3 (VT3)– Advanced Practitioner Level; This is more for the pharmacist who has completed a general Masters' degree and is now looking to specialise; about 5 years' experience. Stage 3 is now being considered in line with the RPS Advanced Portfolio.
Vocational Training Stage 4 (VT4) – Leadership training: this is not part of DS's remit and is part of another project.
Examples of VT3 programmes being developed by NES include: the older patient programme, anti-microbial stewardship programme, clinical trials and public health programme.
NES sponsors pharmacists in the managed service to undertake post-graduate training and also community pharmacists by part-funding. NES also supports independent prescribing training and return to practice training programmes.
There are specialist postgraduate education programmes across the UK which NES will also support pharmacists to access.

Schools of Pharmacy training opportunities:
The Schools of Pharmacy have recently change their Masters' courses in line with the RPS developments around the Foundation Portfolio and the Advanced Portfolio. The two postgraduate courses now include an independent prescribing qualification.
Robert Gordon University (RGU): At RGU, the Diploma is very much aligned with the RPS Foundation Portfolio; it will be possible to achieve a Masters' degree through research or by undertaking a professional portfolio (aligned with the RPS Faculty, Advanced 1 level).
Strathclyde School of Pharmacy: Strathclyde runs a modular programme which starts in September 2015 and will be called Advanced Clinical Pharmacy Practice.

Royal Pharmaceutical Society opportunities:
Foundation Pharmacy Framework (FPF): The FPF is focussed on early years' professionals and is similar to Stage 2; it is very generic to make it applicable to the whole pharmacy profession. It has been developed in a way that community pharmacy can access.
Advanced Practice Portfolio (APP): The APP is available to pharmacists who have been on the GPhC Register for at least 2-3 years; the assessment process is different for pharmacists who have been registered for more than 10 years.

A significant amount of time has been focussed on identifying the differences between the RPS Foundation Framework and the NES VT2 programme; they are different in the way that the evidence is collated and assessed but that is principally because NES has had a

programme in place since 1997 and has had time to develop an infrastructure. The Foundation Framework is also an electronic portfolio but, at the moment, is more about self-assessment, however, this is evolving. The NES VT2 is a 2 year programme in which the trainee collates evidence (based upon the CPD format to avoid duplication), uploads the evidence to an e-portfolio which is assessed firstly by an internal tutor and then externally by NES. The Foundation Framework provides tools for the trainee to self-assess but also their work-place tutor has access and can monitor progress and use the tool to give immediate feedback; this training may be linked to appraisal processes. Within the hospital sector pharmacists are expected to complete the VT2; it is hoped that, once this stage is completed, pharmacists will be keen to strive for the next level.

Whilst scoping and mapping processes, DS has been aware of developments in other areas, for example, NES are looking to develop an Advanced Generalist Stage 3 programme; this will align with Accredited Clinical Pharmacist Independent Prescriber (ACPIP). RPS is also in discussions with the UK Clinical Pharmacy Association (UKCPA) to develop an advanced curriculum similar to NES; part of DS's remit is to look for potential duplication. RPS is also looking at accreditation principles for training providers.

Challenges identified so far:

- NES has a service level agreement around working with the health boards to develop an infrastructure of tutors, trainers and an assessment process. A challenge could be translating this support network from 'hospital' to 'community'; DS acknowledged the benefit of chains of pharmacies, e.g. Rowlands and the Right Medicine, adopting the Foundation Framework and putting it into practice
- The way post-graduate courses are accessed in Scotland is different from how they are accessed in England and Wales with most health boards being linked to a SoP. In England, a newly qualified pharmacist in the managed service would start a diploma in the first six months, whereas in Scotland, pharmacists take a vocational training programme for two years and would then consider a Masters' degree in Clinical Pharmacy; it may be that a pharmacist will complete VT2 and use this in part to obtain prior learning recognition. However VT 2 is not a substitute for academic clinical teaching.
- There are challenges around the quality assurance of training and assessment processes for workplace learning but Scotland has a very good model for pre-registration (pre-reg) across hospital and community and the methods could inform future development in this area.

Next steps:

- To confirm if there are any gaps regarding training
- To link with Fiona Reid who is developing the independent prescriber programme; the independent prescriber competencies will be captured in the RPS Framework in the future.

ASh noted that he had asked the Heads of the SoPs about how their courses map to the core competencies of the Foundation and Faculty. ACB noted that Strathclyde has outcomes for their under-graduate courses that are assessed and accredited against but that there is nothing similar for post-graduate courses. This has meant that the Scottish SoPs have been able to re-design their post-graduate courses to fit with the profession's requirements but at the same time mapping more closely to the RPS Faculty. ASh also

noted that 60% of today's workforce will still be working in 10 years and that every age range needs to be considered not just the newly qualified pharmacists.

AG commented that there is a challenge as to how pharmacists access the courses and that 'a level playing field needs to be achieved' and to be accessible to all. DS agreed and mentioned the 'Aspire' course, run by Boots. JB confirmed that *The Right Medicine* has adopted the Foundation Framework both for newly qualified pharmacists and also with more experienced pharmacists. The early years pharmacists they are only doing one piece of the Framework – the pharmaceutical care section – as the basis of a peer group discussion. With more experienced managers they are using it as an appraisal process with a very professional slant.
AS suggested that a clinical pharmacist should be able to perform in any setting and that all pharmacists should be trained to have a holistic approach to patient care and to poly-pharmacy.
The Chair noted that the complexity of activities that pharmacists are asked to perform on a day to day basis, through *PfE,* shouldn't be overestimated.
SM noted that in at Oban & Lorne hospital, post-graduate educational meetings are held weekly, at which different specialities of medics will present to the group. It is clear that the team relies on the expertise of specialists within the team to deliver optimum patient care.
The Chair concluded this item by thanking DS for her presentation and noting that more time should be given to this project at a Strategy Day.

Action point: BMs to provide details of independent community pharmacy contractor organisations to approach to discuss training and education opportunities.
Action point: AMacK / CR to include the NES / RPS project as an agenda item at a strategy day.

15/35. Royal Pharmaceutical Society in Scotland (RPSiS) National Seminar: 'Pharmacy working together to advance quality practice'.

Annamarie McGregor (AMcG), Professional Support Pharmacist, took BMs through the draft programme; themes will mirror those of the RPS Conference. There will be stand-alone items but also those that subsequently can be taken out to LPFs. It is very important that the programme attracts pharmacists from all settings. Satellite meetings can be rationalised.

<u>Saturday afternoon</u>:
EBr gave a broad outline of the programme for the Saturday afternoon; this will be aimed primarily at students, pre-reg. trainees and newly qualified pharmacists with more experienced pharmacists, for example, Foundation and Faculty Champions, Faculty Members and RPS Fellows attending in a 'mentoring' capacity. The afternoon will focus on the Foundation Programme leading on into the Faculty. Jonathan Burton (JB) will chair the afternoon; JB added that it would be a good opportunity to focus on *Early Years'* pharmacists and the development of young pharmacists but also dovetail this with bringing in experienced pharmacists and Faculty Members and Fellows. It has been found that having a breadth of experience works well at the BPSA Conference and also at LPF careers events. It would also be an opportunity to hold a Faculty celebration event.

- Kim Munro (KM) was concerned that there is clarity around the purpose of the afternoon and also who the target audience is. AMacK confirmed that the afternoon will be targeted towards pharmacists in the early stages of their career but that there should also be activities that appeal to more experienced RPS Members; it was agreed that an element of the Faculty should be incorporated into the afternoon, but

not anything that will be repeated on the Sunday. There will also be an LPF Steering Group (SG) networking event at 5 pm.

- The Chair suggested that the Saturday event should appeal to RPS Members with an interest in mentoring, training and tutoring.
- AS suggested clinical leadership for pharmacists; this is especially pertinent with Health & Social Care Integration where influencing and persuasion skills will be required. This might be an opportunity for NES to host a session.
- SCN asked if there are any trends from the Faculty that indicate what might be of interest to Members. It was agreed that having Faculty Members presenting their personal stories and case studies would bring the process to life. KM agreed, noting that she had been surprised by how much she had got out of the Personal Development Plan at the end of the course and that it would be inspirational for younger pharmacists

Sunday:

AMcG gave an overview of the draft itinerary for the Sunday, noting that it was hoped that research could be run throughout the two days. EBr has recommended Mark Sampson (MS), Director, MS Cube; he is very much involved with patient safety and communication. EBr to make contact and then AMacK to have an exploratory meeting with MS. BMs were asked for input.

It was **agreed** that the new Chief Pharmaceutical Officer (CPO), Prof RoseMarie Parr, should open the Sunday programme, giving the CPO's vision for pharmacy and then MS could focus on patient safety and communication. ACB was concerned that with five workshop 'we are stretching ourselves too wide, that there are too many options'.

DT noted that his earlier comments (by email) had been about the complexity of the programme; he felt that it should be simpler so that a clear message is given. AS suggested that the three workshops (morning) could be combined as a community pharmacy option – quality and pharmaceutical care in community pharmacy. It would be important to ensure that, if workshops are to be combined, the rooms have sufficient capacity. AMacK noted that 'the programme requires fine-tuning, but knits together quite well'; he asked that BMs acknowledge the Directorate team effort to pull the event together. KM asked what else that BMs can do to support the planning and delivery of the event; BMs were asked to identify and provide details of practitioners who might wish to show case 'best practice' and also potential chairs for workshops. The Chair advised BMs of the recent *PfE* stakeholder event and that some of the leads might be appropriate to approach.

SCN requested that the RPS Manifesto 2016 is removed as, by August, it would be too late. Completion of programme within next couple of weeks.

Action point: BMs to feedback how to make the day flow smoother. AMcG to re-work the programme and CR to circulate in the SPB weekly update.

Action point: EBr to make contact with Mark Sampson and AMacK to have an exploratory meeting.

Action point: BMs to identify and provide details of practitioners who might wish to show case 'best practice' and also potential chairs for workshops.

Action point: Chair to provide names of leads at *PfE* stakeholder event

Notices from the Chair

- Scottish Pharmacy Board (SPB): The Chair confirmed that there would be no election in Scotland as there were four candidates for four places, therefore Dr Anne Boyter, Mr David Thomson and Prof John Cromarty were re-confirmed as member of the SPB for a further term of three years and Miss Elaine Thomson was confirmed as a member of the SPB for a first term of three years. ABr noted that, with the retirement from the Board of Sandra

Melville, the hospital sector would no longer be represented on the SPB; she had attended a National Acute Pharmacy Services (NAPS) meeting the previous day and concern was raised about this; ABr asked that the option of co-opting a representative from the hospital sector be considered at the June SPB meeting.

- The Chair intimated that although he had been re-elected to the Board, it was probably not his intention to stand for Chair for a fourth term.
- Dr Colin Cable: Although he was not available, the Chair asked BMs to acknowledge and congratulate Dr Colin Cable on having worked for the Society for 25 years.
- Sandra Melville: The Chair advised BMs that Sandra Melville (SM) would be retiring from the Board and that this was her last meeting. He thanked SM for her contribution over the last eight years and particularly, her four year tenure as Chair, a period which included the de-merger and the establishment of the new Society. SM was given a bouquet of flowers and a card signed by all BMs and the Scottish Directorate team. AMacK reiterated the Chair's words. SM thanked the meeting, saying that it had been 'a huge privilege and a huge pleasure'. SM noted her disappointment that there had not been more nominations for election; she had thought 'long and hard' as to whether to stand again but had concluded that she had been on the Board for eight years and 'that it was time for fresh blood'. SM offered to help if ever required. Helen Gordon (HG) offered her personal thanks for SM's 'dedication' and her 'very strong leadership'.

Action point: Co-option (to ensure that the hospital sector is represented) to be included as an agenda item at the June 2015 SPB meeting.

15/36. '**Out of Hours working'**

AMcG suggested this might be adopted for a strategy day meeting. AMcG gave some background, a review of 'Out of Hours' (OOH) in primary care started in January 2015, there are 31 members in the Group including the Society and Community Pharmacy Scotland (CPS); it is hoped that pharmacy will be represented on all the working groups supporting this review. Two meetings have now taken place, the first one taking place in March and the second in April. Prof Sir Lewis Ritchie, Chair, is very clear that the review shouldn't just be about the GP OOH service and that a multi-disciplinary approach, with a strong pharmacy presence, is required. AMcG suggested that Prof Ritchie should be invited to the SPB day in June as he is speaking to each of the organisations represented on the review group. Time has been allocated for a workshop at the NES RPS Conference as he is keen for 'practitioners on the ground' to offer solutions. One of the key issues is access to the emergency care summary. At the April meeting there was a very helpful presentation which showed that the most frequent 'asks' from NHS24 calls are for are medicines information and also minor ailments. Not necessarily looking at new solutions but how the current services can be promoted and improved. The aim is for a report to go to the Cabinet Secretary by the end of September. AMcG and Harry McQuillan (HMcQ), Chief Executive, CPS are looking at how the RPS and CPS can do some joint events to get practitioners together to consider OOH. JMcA advised BMs that Prof Ritchie had presented to the DoPs on 17 April and that he had made it clear that he is very keen for 'pharmacy's fingerprints to be all over OOH document with recommendations, and that pharmacists at the coal face are engaged with'. He has asked that DoPs together with RPS and CPS to look at how this engagement can happen, using existing networks; this is a great opportunity.

EBl asked if, when considering OOH, is it GP OOH or pharmacy OOH, i.e.24/7; JMcA confirmed that primary care OOH is being considered which would involve a look at both and where pharmacy may be able to provide solutions, but these would require extra

resource. JMcA suggested that appropriate remuneration for pharmacy and maybe an increase in the OOH budget would be required.
SM advised that she had recently given evidence at the Health & Sports Committee about 7 day hospital working, including pharmacy. There was multi-disciplinary representation at the meeting and it was evident that 'everybody was singing from the same hymn sheet, that we could do better for patients with more resources'; there was an element of collaborative working and it was recognised that pharmacy could work well with doctors and nurses but there was an element of competition because there is a finite budget. SM asked if there is a link between 7 day working and OOH as it shouldn't be looked at in isolation and that other sectors would need to be considered. JMcA agreed, noting that this concern has been recognised but the review will only focus on recommendations for primary care OOH.
DT asked what is happening to the GP model of supply which is well remunerated; he suggested that all models should be looked at in parallel.
AMcG suggested that, for clarity, education skills need to be considered, e.g. Pharmore project. AMcG urged that, because of the enormity and importance of this subject, a strategy day should be arranged to allow for further and fuller consideration.
AG suggested that there is a need to educate the public to manage expectations and to understand what is urgent and what is not urgent. Currently, there is not the resource or facilities within a pharmacy to manage patients. AMcG confirmed that there are some quick wins which require identification and implementation and that there are also longer term solutions which will require further consideration.

JMcA concluded the item by confirming that Prof Ritchie is keen that this is not just a 'quick fix' but that the medium and longer term options and needs are considered.

The Scottish Pharmacy Board

Supported

The intention to work with CPS and the DoPs Executive to consider how to progress the pharmacy engagement element of the review and how views and ideas are to be fed in.

Action point: CR / AMacK to arrange a strategy day.

15/37. RPS Conference

Anne Boyter (ACB), SPB representative on the RPS Conference Group, gave an update on plans for the RPS Conference which takes place on 13 and 14 September. There is another meeting on 29 April. Anne will circulate update through the Friday Update. AMacK confirmed that arrangements for BMs to attend the Conference would be the same as in previous years.

Action point: ACB to feedback info from meeting to be held on 29 April. CR to circulate through the Friday Update
Action point: BMs to confirm to CR if they require rooms over the RPS Conference.

15/38. Business Case for RPS Scotland Facebook page

Susanne Cameron-Nielsen (SCN), Head of External Relations, tabled item: 15/04/SPB/12 – Business Case for RPS Scotland Facebook page. SCN confirmed that there is a GB Facebook page, but not a Welsh or English page; ACB suggested that Facebook is not necessarily the social media tool being used by students and that perhaps, other means should be considered. SCN agreed but noted that, in terms of the audience proposed, it will

not just be for students but for all pharmacists. The proposal is for two pages, the first being for all pharmacists and the second being more on public / patient opinion poll focused. An important advantage of Facebook is the functionality that come with it, linking to other platforms. It is not intended that Facebook will become the only platform for communication but will be used when pertinent. Social media needs to be considered on an ongoing basis; SCN advised BMs that RPS does have a GB Facebook page, however, it doesn't seem to adequately service Scottish members as it has a bounce rate of 84.2%.
SM asked about the PR Campaign around this and whether it will have a lifespan. SCN confirmed that a campaign is being developed and the reason it has not been done earlier was entirely due to resource. The first part will be around Twitter and the website, developing a content plan. The PR campaign is included in the Business Plan and focusses on broader engagement with public and patients, talking about what pharmacists do and what services are available – this is in the planning and the seminar in June will provide a platform for engagement with the public and patients and this will help inform the campaign. SCN confirmed that the PR campaign page will have a natural end date as, with the extra temporary resource (until Feb 2016) it is possible to run the campaign, but would not be possible without it.

The Scottish Pharmacy Board

approved

The proposal to create an RPS in Scotland Facebook page and the plan for a Facebook page to support the forthcoming PR campaign.

15/39. SPB Business Plan 2015

Alex MacKinnon (AMacK), Director for Scotland, explained the new reporting mechanism for the Business Plan (BP) and the aim of producing one report that could be adapted and used for all reporting, but mainly the SPB and Assembly. AMacK updated Board Members (BMs) on activities against the SPB Business Plan objectives, noting that progress in all areas was satisfactory apart from the Faculty and Foundation events; this will be addressed in May and June.
Membership: AMacK reported that recruitment is disappointing to date, (53% against a target of at least 55%), although if all of the 2014 pre-reg trainees who are Associate Members are converted to full membership this will increase numbers significantly. CR is to design and produce an electronic form for BMs and Staff to complete and return when a new Scottish member is recruited. AMacK reported on the recent 'speed-dating' events with the pre-reg trainees, held in Glasgow and Edinburgh; he had attended the event in Glasgow and felt that it was particularly successful as there were extra elements including a solicitor presenting on conveyancing, renting and buying property, an expert spoke on how to manage finances, there were 16 experienced pharmacists, from across all sectors, leading the 'speed-dating' EBI and AP attended.
Party Political Conferences: Representatives from the RPSiS have attended all of the Scottish party conferences, advocating for pharmacy, not least of which was lobbying for access and input into the electronic patient record. AMacK is to present a paper on this to the Professional Leadership Body Board (PLBB) on 27 April; his aim is to have a coordinated GB campaign around access and input into the electronic patient record to ensure delivery.

Meetings with the Cabinet Secretary for Health and Well-being (Cab Sec): AMacK reported on an 'excellent meeting with the Cab Sec, on 17 March. The Cab Sec has agreed to meet regularly with the next meeting scheduled for 16 September.
Working jointly with Community Pharmacy Scotland (CPS): AMacK reported that he and Harry McQuillan (HMcQ), Chief Executive of CPS, are considering ways that RPSiS and CPS can work together on joint initiatives. Meeting to discuss arranged for 30 April.

Directors of Pharmacy (DoPs):

- AMacK advised BMs that Gail Caldwell, Chair of the DoPs and 3-4 other DoPs will attend and present to BMs on the June Induction Day, 16 June.
- Members of the RPSiS team, BMs, Dr Catherine Duggan (CD) (Director of professional Development & Support) and two members of her team, Helen Chang and Beth Ward, met with the East of Scotland DoPs to explore areas of joint working. CD had attended a meeting at RGU, Aberdeen and it is her intention to meet with representatives at Strathclyde and to bring in the West of Scotland DoPs.

AMacK noted that the BP needs more time at meetings for consideration and for re-prioritisation.

P. 6 of the business plan which stated that no Strathclyde students attended the BPSA Conference; ACB noted that the BPSA Conference was held this year at a time when Strathclyde was still teaching and the students weren't able to attend.
AS suggested that meetings might be set up with Jason Leitch, Clinical Director at Scot Govt and Michael Kellett, Director of the Quality Unit and also on the *PfE* Steering Board.
EBr asked that communications to members are communicated to the team beforehand. Also if a list for Scotland showing new members each month. ASh to ensure that this is facilitated.
AMcG asked BMs to email her names of volunteers who are 'video-friendly'; it is hoped to produce some videos to complement the Community Pharmacy Hub on the website which is nearing completion.

In conclusion, AMacK asked that the team's efforts be acknowledged.

Action point: CR to produce an electronic form for BMs and staff to complete when recruiting a new Scottish Member. CR to collate.
Action point: SCN to consider arranging meetings with Jason Leitch and Michael Kellett.
Action point: ASh to ensure that communications to members are communicated to the team beforehand and also that a monthly list of new Scottish Members is made available to the team.
Action point: BMs to email AMcG names of volunteers who are 'video-friendly'; it is hoped to produce some videos to complement the Community Pharmacy Hub on the website which is nearing completion.

15/40. Prescription for Excellence *(PfE)*

Alex MacKinnon (AMacK), Director for Scotland, reported on a PfE Stakeholder event and also the recent meeting of the *PfE* Reference Group, held on 15 April 2015.
PfE Stakeholder event: The stakeholder event took the form of a speed-dating exercise where the Speakers swapped tables. The Alliance was represented, being very much a fundamental partner with the Scot Govt regarding *PfE; '*patients are right at the centre of *PfE'.* ABr attends the Alliance Patients' Forum on behalf of RPS. Other Speakers included

Clare Morrison on the delivery of pharmaceutical care into dispensing doctor practices which is proving very successful in certain areas. Fiona Reid gave an update from the educational perspective, Colin Dougall on holding clinics in GP surgeries, Pamela Mills taking the perspective of the acute pharmacy prescriber. Discussions followed on communication and engagement. AG agreed that it was a very interesting event but it was useful to bring some pragmatism and reality to the groups. AMacK confirmed that the general public does not fully understand the role of the pharmacist. Both AG and AMacK had been disappointed that IT was to be 'parked'; because IT appears on all three of the GB country's pharmacy strategies and direction of travel as a key enabler. Many patients and the public believe that pharmacists have access to the record already. AMacK was assured that IT and e-health is being addressed but he is keen to have timelines. He suggested that he and SCN should contact the e-health team to determine progress. AMacK agreed that absolute clarity is required, as this is something that has been agreed across all three countries at Govt level. He is not concerned that it won't happen, but 'doesn't understand the how and the when yet'.
AS noted that not having appropriate e-health access raises a patient safety issue around community pharmacists who have to go in to a GP practice first to either print off the 'summary' or to look at the patient record before they will prescribe in the community pharmacy. ASh confirmed that the GPhC, as a regulator, is articulating this and saying that it is unsafe; this is likely to be a 'real driver' for the Government if this is the regulator's view.

PfE Reference Group: This meeting followed on from the Stakeholder event. There is now a better focus on what is required, with progress reports being produced; these will eventually be in the public domain. There was an update on key priority areas followed by a session on communication and communication channels and how they would work across different organisations. A mapping exercise is underway and updates will be released from the Scot Govt to be circulated as widely as possible.

PfE Steering Board: In the Chair's absence, AMacK reported on the *PfE* Steering Board, which is focussing on communication and how the channels of communication can be improved.

EBl stated that, if he wasn't an SPB Member, he would know nothing about the progress of *PfE*. AMacK confirmed that the work groups are at different but very early stages in the 10 year plan; once the organisational framework is established, messages will start to flow. ACB noted that it is very difficult to find out who the members of the working groups are from the website. AMacK agreed to feed this back to the Reference Group.

Action point: AMacK to submit a paper to the PLBB asking for an advocacy campaign around e-health and access and input to the electronic patient record.
Action point: AMacK and SCN to investigate the progress of the e-health strategy through the Scot Govt Pharmacy Department. SCN to set up a meeting with the e-health lead.
Action point: Alex to feed back to the *PfE* Reference Group, that it is difficult to find certain information on the Scot Govt's *PfE* website.

15/41. Pharmacists in GP practices

Aileen Bryson (ABr), Scottish Practice and Policy Lead, advised the Board of a paper that Elaine MacNaughtan, RCGP Scotland had submitted to RCGP Council. She explained the papers submitted to the SPB were a 'tartanised' version of the English paper. As much of the language of the English paper was kept as possible so that it would be recognisable to RCGP (as had been done with 'Breaking down the barriers' a few years earlier). ABr tried to

weave in the current position with *PfE* and the flexibility that is required and what has already been stated as policy from *Wilson and Barber.* ABr has consulted with the SPAA Group which is keen to work with the RPS on this. ABr asked BMs for their comments on specifics contained within the papers (Items: 15.04/SPB/15 &15.04/SPB/15-app1), and for a clear policy position on pharmacists in GP practices, why Scotland differs from England and Wales and what the key issues are for pharmacists and GPs working together. ABr also asked BMs for one thought on pharmacists working in GP surgeries.

DT noted that there had been an article in the Pharmaceutical Journal which inferred that GPs would employ pharmacists; DT asked for clarity around this as he believed that this would be detrimental in Scotland. ABr noted there are differing views on this matter; there are those who think it would be detrimental and those who believe that GP practices are changing and many GPs are employed rather than partners and so they would be on an equal footing. DT's concern is that, if a pharmacist is employed by the GP practice, kudos won't be given to the pharmacist. *PfE* mentions general practice pharmacist, he suggested that this terminology might be considered. ASh confirmed that the key element is to maintain a role that is supporting patient care not supporting the GP. AS agreed, stating that there should be professional autonomy and that there are 'different ways to skin a cat but to remain open to all options'.

SM was concerned that pharmacy is the only profession that has three sectors, i.e. secondary care, primary care and community, whereas every other healthcare profession has two; she felt that this should be broken down. All pharmacy should be patient focused. She had thought that *PfE* would provide an opportunity for a community pharmacist to be more involved with patient care.SM suggested that removing sectors would provide 'a massive opportunity' to start working more collaboratively with pharmacists who work in the community.

AG suggested that if an appointed pharmacist works in a GP surgery, it might preclude consultation with other community pharmacists. He also questioned where the funding would sit as would be preferable for it to sit with pharmaceutical services rather than the GP surgery.

AP questioned the need to be prescriptive about the source of employment and whether this would need to be stated in the paper. ABr confirmed that there would be no need to consider the source of employment.

ASh cautioned that solutions are being sought to the issue of GP shortages and that, pharmacy holding back, may provide an opportunity for other HCPs to fill the void. Also, the purpose and value of what the pharmacist provides for patient care, wherever it is, is more important than how it is developed. Having pharmacists and GPs working together to provide pharmaceutical care for patients is what is important

ACB agreed with AP and ASh, suggesting that physiotherapists in surgeries maintain their autonomy regarding treatment. She recommended that Aileen contact Elaine Thomson, future BM, who is already working in a GP surgery.

EBl asked who the main driver is for this, is it the GPs or pharmacy? The challenge is to get our policy to a place which is beneficial to both RCGP and pharmacy.

AMcG urged caution around transparency and governance, this was a matter of concern to the SPAA Group.

ABr concluded that it would seem from BMs comments that they agreed with the draft paper, a lot of which was previously stated in *Wilson and Barber*, i.e community must be involved, it mustn't be excluded and that it can only be of benefit to GPs to collaborate with community pharmacists who know their patients and understand their pharmaceutical needs. The SPAA Group is very supportive of this view and that different models will be required dependent on situation, e.g. remote and rural areas.

AMacK reminded BMs that what the *Wilson & Barber Review* stated and that what *PfE* is trying to deliver is about delivering pharmaceutical care in a better way across all care setting; 'undoubtedly pharmacists and GPs must work together for that to happen'. The one thing for him it is absolutely vital to maintain professional autonomy using different models; there is an opportunity to do this within *PfE*. HG welcomed the round table conversations and the statement that Ash made.
AS noted that 'time is of the essence', GP surgeries are shrinking; there will be a capacity issue and undergraduate training is vital.
Round table comments from BMs:

- 'Build on existing relationships' (AG)
- 'Document was excellent' (JB)
- 'Patient focused' (AP)
- We are not mini doctors, we are specialists in medicines' (SM)
- 'Equal partners in care provision' (JMcA)
- 'Independent practitioners' (ACB)
- Respect professional autonomy (DT)
- 'that pharmacists have the skills ready - up-skilling and capacity' (EBl)
- ? (KM)

ASh suggested that this is an opportunity to work with the British Medical Association to ensure adequate funding in primary care.

Action point: BMs to feed back on the emailed document to ABR; she will then re-circulate – 14 days.

15/42. Science and Research Update (i)

The Scottish Pharmacy Board

noted

the Science and Research Update (Item: 15.04/SPB/16(i)).

Professional Support Update (ii)

The Scottish Pharmacy Board

noted

the Professional Support Update (Items: 15.04/SPB/16(ii), 15.04/SPB/16(ii)-app1 and 15.04/SPB/16(ii)-app2).

Library and Museum Update (iii)

The Scottish Pharmacy Board

noted

the Library and Museum Update (15.04/SPB/16(iii))

Action point: BMs were asked to feedback any questions through Carolyn

15/43. Key Messages

It was agreed that the key messages from this meeting should be:

- Pharmacist Support
- Scottish Patient Safety Programme
- SCN suggested it would be good to get some 'blog' pieces around the speakers' presentations.
- SPB emphasised the need to keep IT on the agenda
- Pharmacists in GP practices

15/44. Any other competent business

- EBl had raised the issue of agendas being too full for meaningful discussion and suggested making better use of strategy days. He also raised the issue of Assembly members' views being recorded in the *Chemist + Druggist (C+D)*. ASh suggested that there is a difference in England re: script charges, as there are charges in England but nowhere else. SM noted that, irrespective of what was stated in the *C+D*, the Governance Handbook makes it very clear that an RPS representative must align him / herself to RPS policy.
- Strategy days: It was agreed that strategy days should be triggered in. Two x two day meetings and then two triggered in between. AG suggested extending meetings into the evening
- SM noted that, having stepped down from the Board, that there will no longer be a representative to input into hospital issues; SM noted that she would be keen to provide this input when necessary. ABr concurred and said that the NAPs Groups were also concerned. ABr suggested that Chairs of groups attend.

Action point: CR to circulate dates of strategy days.

15/45. Date of Next Meeting

The date of the next meeting will be 16 June 2015.